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Title: Public enterprises in the healthcare sector – a case study of the Queen Elizabeth Hospital, Greenwich, England

Abstract

This article responds to a call for more studies of public enterprises with a case study of a public healthcare enterprise, the Queen Elizabeth Hospital (QEH), in Greenwich, England. The QEH was the first hospital to be placed "in administration" since the NHS was founded in 1948. The QEH is a Private Finance Initiative (PFI) hospital. The impact on the QEH, as a PFI hospital, of changes in legislation and bureaucracy and new arrangements for NHS marketisation are examined. The path to being declared an "unsustainable provider" is outlined, with a critique of the recommendations for the merger of the QEH with another local hospital.

Journal of Economic Literature (JEL) code(s):
H 83 Public administration: Public Sector accounting and audits
I18: Government policy, regulation and public health

Six key words or phrases that characterise the contents of the paper: Public enterprise, healthcare, marketisation, public-private partnerships, public policy, regulation

1. Introduction

The origins of public enterprises can be traced back to the different ways in which the state has intervened in the economy. A public enterprise may have taken over the role of service provider from the private sector. In the United Kingdom (UK), either local or central government took over utilities companies in the late nineteenth and early twentieth century. In both the UK and France, industries were nationalised after the Second World War. Public enterprises have also been identified with strategies for social and political unification and promoting economic development (Millward 2011**).**

By the 1970s, some of the arguments for public sector reform highlighted how inappropriate and inefficient public enterprises were and these failings underpinned the adoption of privatisation and liberalisation policies (Florio, 2004). There was an assumption that the private sector was more efficient than the public sector. However, after almost twenty years of privatisation and public sector reform, state-owned or public enterprises are still an important force in many economies. In Brazil, China and Russia, the emerging economies, state-owned enterprises are playing a significant role in the economy (Economist 2012). In Europe, there are a wide range of public enterprises that have been maintained or have evolved during the implementation of privatisation and internal market structures.

The continued existence and evolution of public enterprises has important implications for the future of policies for privatisation and public sector reform. If public enterprises are operating successfully then is privatisation necessary? Bernier (2011) argues that governments should attempt to reform the governance of public enterprises rather than privatise them.

In 2011, Florio and Fecher called for a new discourse on public enterprises to be informed by a research agenda that explores how public enterprises were created, how they have evolved during the period of privatisation and public sector reform and why some public enterprises have survived and some failed. Many of the studies of public enterprises have focused on public utilities, such as water, waste management, energy and telecoms. The study of public enterprises in health and social care has generated a relatively small body of research (Doolin 2002; Rego *et al* 2010). This article responds to the call by Florio and Fecher (2011), by using a case study a public healthcare enterprise in England (UK).

This article uses a case study of the Queen Elizabeth Hospital (QEH), Greenwich, England to show how legislative and bureaucratic changes affected a public health enterprise, which was one of the first hospitals built under the Private Finance Initiative (PFI). The Queen Elizabeth Hospital (QEH) was chosen because it was the first hospital to be declared bankrupt in 2012 since the NHS was established in 1948.

There are three research questions:

- How did changes in legislation and bureaucratic procedures affect the QEH?
- How did new national arrangements for marketisation of the NHS impact on the QEH?
- What was the path to bankruptcy?

Data was collected from a range of published documents. National legislation and plans, advice and guidance issued by the Department of Health were analysed to form a basis for understanding the changes in the NHS during the period 1990-2013. Several public interest reports, commissioned over the last decade provided important financial data. Annual reports and other NHS publications have been drawn on, although earlier annual reports for the QEH for the period before 2005 were difficult to find. National staff surveys and quality inspections for the QEH were used to confirm whether their experience was common to the NHS or unique to the QEH. There were some difficulties in providing consistent data for the whole period 2001-2012 because of the merger of the QEH to form part of the SLHT.

Attendance at early meetings of the Greenwich LINk (patient representative organisation) following the announcement of the bankruptcy highlighted the level of local feeling against the terms of the PFI contract. Local and national newspapers were consulted for the public response to the bankruptcy. A consultation organised by the Trust Special Administrator about the future of the QEH drew in a wide range of stakeholders who gave detailed accounts of how they saw the future of the QEH. This provided useful evidence of the wide range of stakeholder views on the impact of the Private Finance Initiative. These extensive results were made available to the public and were used in this study.

The article is structured in three sections: legislative and bureaucratic changes; national arrangements for marketisation; Becoming an “Unsustainable Provider”.

2. Legislative and bureaucratic changes

This section outlines some of the key legislative and bureaucratic changes that were introduced in the 1990 Health and Community Care Act and later, which influenced the way in which the QEH Private Finance Initiative (PFI) contract was drawn up and negotiated. The PFI initiative needs to be understood in the context of changes to the way in which hospitals had to account for capital charging. New accountancy guidelines were drawn up for companies and public authorities involved in PFI contracts.

In the UK, the 1990 NHS and Community Care Act introduced an internal market to the National Health Service. It created provider institutions by transforming hospitals and other healthcare services into NHS Trusts, which were a type of public enterprise. The governance of an NHS Trust was determined by the provisions set out in the 1990 NHS & Community Care Act, which stated that an NHS Trust (a) shall be "a body corporate having a board of directors consisting of a chairman appointed by the Secretary of State and …… executive and non-executive directors (that is to say, directors who…. respectively are and are not employees of the trust" (Health & Community Care Act 1990,12A). This Act also specified that the Secretary of State (for Health) was responsible for appointing a Chair and directors of an NHS Trust, setting the maximum and minimum numbers of directors, the process of appointment, and the "appointment, constitution and exercise of functions by committees and sub-committees of the trust". The 1990 Act gave the Secretary of State for Health extensive powers in the appointment of the Trust Boards, committees and sub-committees. This was the formal structure which was introduced for "self-managing NHS Trusts" in 1990. In contrast with previous NHS governance structures at local level, for example, district health authorities or family practitioner committees, there were no representatives from the local community, local authorities or doctors.

In 1990, District Health Authorities became the public bodies responsible for identifying the health needs of the local population and commissioning services from local providers, for example, NHS Trusts. Service Level Agreements were drawn up between district health authorities and NHS Trusts, a precursor to the introduction of commercial contracts.

In order to function as a quasi-market, public sector institutions, including NHS Trusts, were subject to a process known as corporatisation and had to operate within business objectives,

aiming to make a profit, working to targets and new quality standards (Leys 2003). The new NHS Trusts were subject to a new capital charging system. Until 1990, hospitals received capital grants for infrastructure developments from the government. After 1990, the NHS Community Care Act made trusts responsible for capital financing. Trusts had to pay for use of capital in the same way that the private sector depends on shareholders (Gaffney *et al*, 1999).

NHS Trusts, as part of a new way of presenting balance sheets, were required to operate with an annual surplus of income over expenditure which was equal to 6% of the value of their assets. Depreciation also had to be charged for. Hospital capital was defined as a liability with the government as creditor and sole shareholder (Gaffney *et a 1999*). Liability was defined in terms of replacement costs, which were higher than the original cost. A 6% charge was paid for these assets. This had implications for the QEH (and other PFI hospitals) when a new payments system was introduced after 2006, which will be discussed in Section 3.

The new system of capital charging led to NHS Trusts having to search for new sources of capital. The Private Finance Initiative (PFI) was introduced by the United Kingdom (UK) central government in 1992 for public services to access capital from the private sector to modernise and improve public service infrastructure (Hellowell and Pollock 2007). The Conservative government, at the time, wanted to limit the public sector borrowing requirement so it could keep tax increases low (Gaffney *et al* 1999; Whitfield 2001). Partnerships with the private sector were considered a way for the public sector to access capital funding for infrastructure improvements without the increased capital borrowing appearing as public sector debt, so they were 'off-balance sheet'. However, although PFI contracts did not appear on national accounts, there were still costs to be made by government over the length of the contract, which were often between 30 and 60 years (Heald and Geaughan 1997). PFI contracts were arranged for a wide range of infrastructure projects, for example, bridges, schools, roads as well as hospitals.

PFIs continued to be encouraged after 1997 (Gaffney *et al* 1999; Hellowell and Pollock 2007). The 1997 National Health Services (Private Finance) Act, together with the 1996 NHS (Residual Liabilities) Act, ensured that the public sector was legally required to make PFI payments, so reassuring the private sector that there would not be defaults in payment. It made it much simpler for NHS Trusts to enter into private finance initiatives with the private

sector. The view of the new Labour government, elected in 1997, was that investment in health and education infrastructure was a priority and the private sector was considered a reliable source of capital, even though some of the risks of the long term contracts were beginning to be publicised (Pollock and Dunnigan 1998). On 10 June 1997, the Secretary of State for Health, Alan Milburn, announced that 14 new acute hospitals would be built under the PFI scheme. In October 1997, in a speech at the Labour Party conference, a fifteenth hospital, Queen Elizabeth Hospital (QEH) Greenwich, was added to the list (Pollock and Dunnigan, 1998).

The PFI contract for the QEH is a "whole" hospital scheme which covered the building of a completely new hospital, rather than a wing or section of an existing hospital. PFI contracts are made up of two parts: a Unitary Payment, which consist of an Availability element and a Service element. The Availability element funds annual capital charges associated with provision by the company or consortium of assets and the Service element funds the cost of providing services. The Availability element funds the hospital assets and the Service element funds the cost of providing facilities management services for the hospital. The PFI contract is for 60 years, which is made up of a 30-year contract with options to extent for two 15 year periods. The annual payments from 2004/5 to 2009/10 increased from £23.4 million per year to £26.5 million (Cambridge Economic Policy Associates Ltd (CEPA) 2007).

In the case of the QEH, the PFI contract is with a company called the Meridian Hospital Company plc, which is a "Special Purpose Vehicle (SPV)" set up by the investors, John Laing, to run the hospital. The Meridian Hospital Company plc is a subsidiary of John Laing, sold to the John Laing Capital Management, which manages the company. The Meridian Hospital Company plc delivers facilities management services by contracting out to Mediclean and "hard" services by contracting to Skanska Rashleigh Weatherfoil Limited and Vinci Construction UK Limited (PartnershipsUK 2009). The ownership arrangements are opaque and details of profits generated from the PFI contract difficult to trace (Shaoul *et al* 2008).

The Unitary payment is a constant annual amount in real terms for the first 30 years and increases in line with retail price index. The Availability component of the Unitary charge is a fixed annual amount in real terms, indexed for movements in the retail price index, until the

end of the first 30 year contract, and is much higher during the first 30 years than at the end of the 60 years. During the second 30 year period the Availability charge will be reduced.

The funding of the QEH PFI contract was financed by a bond issue. The cost of the debt is high (4.9%) and fixed for the life of the bond issue. Breakage costs are very high which means that early termination, renegotiation or refinancing were not possible (PriceWaterhouseCoopers,2005). This has been a major problem in trying to address the annual deficits recorded by QEH. The PFI deal was only shown to be value for money if:

1. Unidentified cost savings of £8 million were made;
2. The length of contract was extended from 30-60 years with a lower Availability payment for the second period.

Even with £8 million cost savings, the cost of borrowing for 30 years was more expensive than the Public Sector Comparator (CEPA 2007). The Public Sector Comparator is a way of estimating what a PFI capital project would cost if the public sector raised money. If estimates showed that the public sector option was cheaper, then the project should be delivered through public procurement. However, this very rarely happened because of the way in which risk was estimated. Gaffney *et al* (1999) found that the public authorities estimating risk for the public and private sector in different ways and often attributed risks to the private sector that they would not realistically have to bear. The costs of these additional risks were then added to the costs of the Public Sector Comparator (PSC), thus making the PSC cost much higher than the PFI cost.

The QEH PFI contract was negotiated in the late 1990s when PFI contracts had to demonstrate value for money in relation to the cost of public finance, or Public Sector Comparator, which, at that time, was 6% in real terms. Since the 1990s, there has been a reduction in the cost of public sector borrowing from 6% to 3.5%. This has led to a reduction in the dividend on public dividend capital paid on public sector borrowing for non-PFI hospitals, so that it is now cheaper for non-PFI hospitals to borrow through the public sector (CEPA 2007).

Although government saw private capital as the solution for long term investment in public services, there was little recognition of the skills and expertise required to negotiate large construction contracts. The internal market had only been introduced in 1990 and an influx

of private sector managers into the NHS had not taken place. Consequently PFI contracts were negotiated by NHS managers, with little experience of the private sector or, large, complex commercial contracts. Nor were they aware of the implications of some of the capital charges introduced by the 1990 Act. Although there were critics of the new PFI contracts, government policy did not change. The terms of PFI deals were negotiated without any apparent understanding of how the repayments would create deficits for NHS trusts, although critics, such as Pollock, correctly predicted the impact of the PFI payments on hospital budgets and public health (Pollock, 1998).

3. National arrangements for marketization

This section outlines how several measures designed to enhance the process of marketization in the NHS, after 2000, had an impact on the QEH. A new system of resource accounting and budgeting changed the way in which expenditure and income were presented in NHS Trust accounts. Payment by Results (PbR) created a set of standardised prices across the NHS. The introduction of a new form of public enterprise, the Foundation Trust, gave greater independence to some NHS hospitals. A fourth development was the Health Act (2009) which introduced the concept of (Un)sustainable Providers, which was to impact on the QEH.

For the QEH, which began to show a deficit after 2002/3, the NHS "Resource Accounting and Budgeting" (RAB) scheme introduced in 2001, had a significant impact. The RAB scheme is based on recording expenditure incurred and income earned in an accounting period rather than cash payments and receipts (Shaoul *et al*, 2008). It is widely used in the private sector. RAB reporting requires NHS Trusts, when recording a deficit, to have the amount equal to the deficit subtracted from the funding allocation for the next year. For the QEH which recorded a deficit from 2002/3, the RAB requirement led to annual increases in the deficit. In 2006, the Audit Commission recommended that NHS Trusts should be exempt from the RAB scheme (Guardian 2006).

The Department of Health introduced a new system of payments for healthcare in 2004/5, which was called Payment By Results (PbR) (Department of Health 2012). Prices for treatments in "Health Related Groups" were introduced. This new pricing system was based on a model called Diagnostic Related Groups (DRG), developed by Medicare in the United States in 1983 as a way of controlling costs. This system has been promoted in many

European countries (Mikkola *et al* 2001). New DRG pricing systems in national healthcare systems have been adopted by many countries as part of health sector reform but are subject to extensive criticism from several perspectives. Prices are based on the estimated cost of care for a patient and form the basis for reimbursement, whether from government or social insurance fund. The costs assume that patients have similar characteristics and use similar amounts of resources (Bocking *et al* 2005). DRG systems of pricing are often introduced to try and reduce health care costs and increase profits. If used across a country, there can be differences in how patients are coded (Coory & Cornes 2005). DRGs do not necessarily capture the complexity of patients with more than one condition and the implementation of DRGs may raise ethical issues (Fourie *et al* 2013).

By 2006/7, all NHS trusts were paid a standard tariff for each patient, which was based on the average cost of providing treatment for a patient across the NHS (Hellowell and Pollock 2009). The Department of Health introduced a "Market Forces Factor" (MFF) which aimed to provide an adjustment to Payment by Results tariffs by taking into account non-controllable regional cost variations, for example, capital costs. This adjustment would fund the difference between actual costs incurred by the trust and national average costs (Department of Health 2013/4).

Many PFI hospitals, particularly the QEH, found that the Market Forces Factor for capital costs did not cover their higher than average capital costs. The funding of capital costs in the PvR tariff was based on national average capital costs, informed by the Public Dividend Capital (PDC) of 5.8% when the QEH PFI contract was finalised (Hellowell and Pollock 2009). However, the actual cost: capital costs for QEH were 12.3% (Palmer 2007). As a result, the QEH, with higher than average capital costs, was not covered fully by the capital costs component within the tariff (CEPA, 2007).

In response to the growing annual deficits of the QEH and a nearly PFI hospital called the Princess Royal Bromley Hospital, a five year plan entitled "A Picture of Health' (2007), was drawn up by the Strategic Health Authority (for London), which attempted to reconfigure acute services in South East London. The plan observed that the QEH had the least scope to reduce its fixed costs and would only be able to improve its financial position if it increased its capacity to deliver services (A Picture of Health 2007). The final reconfiguration of services resulted in the merger of the QEH with two local hospitals, the Princess Royal

Bromley Hospital and Queen Mary Hospital, Sidcup. The Princess Royal Bromley Hospital also had a deficit caused by a PFI contract. The ultimate result was that there was no reduction in the deficit for the new combined NHS trust, which was called South London Healthcare NHS Trust, but rather an increased annual deficit.

Although the 1990 NHS and Community Act had created a form of public enterprise for the NHS, called an NHS Trust, legislation in 2002/3 introduced a new form of "public benefit corporation" for the NHS, which was authorised "to provide goods and services for the purposes of the health service in England" (Health and Social Care (Community Health and Standards) Act 2003). These new "public benefit corporations" were called Foundation Trusts and given autonomy to make their own financial and strategic decisions. As well as providing healthcare services, Foundation Trusts are allowed to "carry on activities other than those mentioned in subsection (1) (purposes related to healthcare),……for the purpose of making additional income available in order to carry on its principal purpose better" (Health and Social Care (Community Health and Standards) Act 2003). Foundation Trusts are allowed to invest their own money, form partnerships with the private sector and lend money, thus making them operate in the same way as private companies. They have been taken out of Department of Health control. Pollock *et al* 2003 emphasized that Foundation Trusts will be driven by financial risk rather than patient need. The 2012 NHS and Social Care Act expanded the scope of Foundation Trusts to generate income from 10% to 49% of their budget. This change showed that Foundation Trusts were considered by government to have an important role to play in increasing the process of marketization in the NHS.

Initially, this new form of public enterprise was supposed to be for larger NHS Trusts, such as teaching hospitals, which wanted scope to expand services and raise capital. After 2010, and with the approval of the 2012 Health & Social Care Act, all NHS trusts were required to move towards becoming Foundation Trusts. Each NHS Trust had to draw up a plan for meeting the conditions required to become a Foundation Trust. The application of the South London Healthcare Trust (SLHT) to become a Foundation Trust was one that had political implications, as can be seen in a debate of the Parliamentary Public Accounts Committee in 2011. The government was unwilling to admit that the reason that SLHT might not be successful in meeting the criteria to become a Foundation Trust was because of continued financial problems caused by its PFI contract (Public Accounts Committee 2011). This

indicates that the continuation of a PFI contract for South London Healthcare Trust was considered a government priority.

In 2011, the South London Healthcare Trust had to agree to work towards meeting the conditions necessary to become a Foundation Trust. A Tripartite Formal Agreement between the South London NHS Healthcare Trust, NHS London and the Department of Health, which outlined the actions needed for the SLHT to achieve Foundation Trust status was drawn up and signed in 2011. This Agreement set out the performance of the Trust in relation to clinical standards, which were already met, to a certain extent. SLHT's clostridium "difficile" infection, a type of bacterial infection that can affect the digestive system and found most often in hospital patients was lower than the national target but it was found not to be meeting the 18 week target for all patients to see a consultant. Both the QEH and SLHT had failed to meet this national target over several years. The Tripartite Agreement was unable to set a formal date for the submission of SLHT's application to become a Foundation Trust because of continuing financial problems at SLHT (NHS/Department of Health 2011).

The 2009 Health Act introduced the concept of a "regime for unsustainable NHS providers". The aim was to deal with poorly performing hospitals, which are unable to improve their performance, as defined by the NHS performance framework. The basic principles that informed the creation of a "regime for unsustainable providers" and which informed the way in which the regime was managed were: the need to protect patient interests; to recognise that state-owned providers are part of the NHS system; that the Secretary of State is accountable to Parliament for the NHS; to recognise the importance of involving staff in the process and; to make solutions "credible and workable" (Health Act 2009). Although there was an apparent commitment to seeking solutions, there was also a strict timetable which had to be followed after a hospital was declared "unsustainable", which provides little time for the development of any solutions. The continued deficits of the South London Healthcare NHS Trust (SLHT) resulted in it being the first NHS Trust to be declared an "unsustainable provider" in 2012. The results of this decision are discussed in section 4.

New national systems of accounting and pricing and pressure to establish new forms of public enterprise all had an impact on the functioning of the QEH and later the South London Healthcare Trust (SLHT). The new pricing system contributed to increasing annual deficits because the Market Force Factor (MFF) allowance for capital payments did not cover the

costs of the PFI interest payments. The pressure by government for all NHS Trusts to convert to a Foundation Trust status placed the South London Healthcare Trust in a position where it was unable to satisfy the conditions to become a Foundation Trust. The introduction of the concept of "Unsustainable providers" in the 2009 Health Act showed that Department of Health was unwilling to continue to support NHS Trusts with continuing deficits.

4. Becoming an "Unsustainable Provider"

This section outlines the events that led to the South London Healthcare Trust (SLHT) to be put into administration and the subsequent response by central government. The trigger for the Department of Health to declare the South London Healthcare NHS Trust (SLHT) "unsustainable" was the Audit Commission report of 2012 which declared the Trust financially unviable. The financial regulation of NHS Trusts and local authorities was the responsibility of the Audit Commission (Audit Commission 2012). Section 8 of the Audit Commission Act, 1998 which set out the responsibilities of the Audit Commission, stated that the audit process "requires the Audit Commission to consider whether, in the public interest, I (the auditor) should make a report of any significant matter coming to my attention". Under section 19 of the Audit Commission Act, 1998, the auditor had a duty to make a referral to the Secretary of State "if I have a reason to believe that the Trust has made, or is about to make, a decision involving unlawful expenditure, or has taken or is about to take, unlawful action likely to cause a loss or deficiency".

The Audit Commission issued a "Public Interest report for 2011-12" for the South London Healthcare Trust (SLHT). It observed that even when the SLHT was being set up in 2008/9, a due diligence report found that there were gaps in the financial information available and weak systems of financial control. There were risks that the new trust would fail to make cost reductions because of performance levels in previous years. These pre-existing conditions did not provide a strong basis for financial planning in the newly formed Trust (Audit Commission 2011/12, 5). Consequently, savings targets for the period 2009/10-2011/12 were not met.

The Audit Commission identified three reasons for continued levels of deficits. Firstly, the terms of the PFI contracts that both the QEH and the Princess Royal Bromley Hospital had to paid until 2028. Secondly, inadequate capacity of estates, workforce and beds needed to be

improved. Thirdly, as a result of high turnover of staff, the quality and capacity of senior management was inadequate for the task of managing a merged NHHS Trust. Internal audit and internal control was also weak (Audit Commission 2011/12 6-9).

The Audit Commission concluded that "the Trust is not sustainable in its current form*"* without significant on-going external funding. The size of the deficit and the level of overcapacity in south London could not be addressed with the existing configuration of three hospitals and the current PFI contractual obligations (Audit Commission 2011/12:12). This conclusion led the Audit Commission to issue a report "in the public interest" under section 8 of the Audit Commission Act, 1998 (Audit Commission 2011/12). As a result of this conclusion, the Secretary of State for Health suspended the Trust Board by instigating the "Unsustainable Provider Regime" and appointed a Trust Special Administrator in July 2012. This shows how the judgements of the financial regulator informed decisions by the Department of Health.

Placing NHS trusts "into administration" was considered to require a new and "bespoke" system of special administration (Department of Health 2009). There was no insolvency scheme for NHS Trusts. The Health Bill (2009) made the provision for a Trust Special Administrator, who would be appointed to run the NHS trust and then draw up, in consultation with local stakeholders, a plan for the future of the trust.
As part of the implementation of the "Unsustainable Providers Regime" the Secretary of State for Health appointed Matthew Kershaw as the Trust Special Administrator (TSA), previously Director of Provider Development in the Department of Health (Department of Health 2012c).

In July 2012, the Board of SLHT was suspended and the Trust Special Administrator took over the running of SLHT. Within the required 45 working days, he produced a draft report setting out a future strategy for SLHT. A consultation process was set up with local stakeholders, which had to take place within 30 days. In the light of the findings of the consultation process, the TSA finalised the report within 15 days and the Secretary of State then presented it to Parliament within 20 working days. This sequence of events meant that decisions about the future of the SLHT ware made within six months of being declared "unsustainable".

The solution presented to the Secretary of State for Health and accepted by him was to break up the South London Healthcare Trust (SLHT) into the three hospitals that had been merged in 2009. The QEH would merge with another local hospital, Lewisham NHS Trust, which had expressed interest in merging with the QEH because as part of a larger hospital, it would have a better chance of becoming a Foundation Trust. The terms of this merger were that the Accident and Emergency department and maternity services of Lewisham Hospital would be downgraded because QEH has large departments for these services (Office of the Trust Special Administrator 2013).

There was local outrage to this proposal and a successful local campaign took the Department of Health/ Secretary of State to court to contest the decision. In October 2013, the Court of Appeal ruled that the "Health Secretary Jeremy Hunt did not have power to implement cuts at Lewisham Hospital in south-east London"(BBC 2013). However, this did not mean that the decision to merge the two hospitals was overturned. The merger took place on 1 October 2013. Lewisham Hospital has a PFI contract, which was negotiated more recently than that of the QEH and the hospital is not yet in deficit. This merger will, again, bring two hospitals, with PFI contracts together. It shows the failure of the Department of Health to learn from the problems caused by the 2009 merger of the QEH with two other local hospitals and the risks inherent in the scale of PFI payments. There were no opportunities for a longer process to decide the future of the hospital which could have involved local stakeholders.

After a decade of continued deficits at the Queen Elizabeth Hospital (QEH), one of the final recommendations of the Special Trust Administrator was that the Department of Health should pay the financing costs of the PFI contract from the funding for health services in Greenwich. This showed that the government felt that payments for the PFI contract had to override any considerations of terminating the contract, an attitude that the government had taken since the contract was negotiated. The private sector continued to benefit throughout the financial crisis of the QEH. Many stakeholders in the consultation, organised by the Trust Special Administrator, felt that the PFI contract was damaging to the hospital but did not argue for resources to be taken away from the local health budget.

5. Conclusion

Although NHS Trusts were established in 1990 as a form of public enterprise, their scope for taking their own decisions was actually limited, especially when part of a PFI contract. The

QEH illustrate many of these problems. Changes to accounting and capital charges were damaging to the financial position of the QEH. The Department of Health retained extensive influence, both directly and by working through strategic health authorities and local health commissioners. The continued control by the Department of Health influenced the way in which the QEH dealt with its growing financial crisis and was influential in the inadequate solution to merge QEH with two neighbouring hospitals. The persistent support by the Department of Health for the QEH PFI contract is indicative of a strong commitment to maintaining the contract with the private sector, even when it was damaging to the long term interests of this hospital.

The role of the financial regulator was shown in this case study to be essentially supportive of the Government and played an instrumental role in making the QEH declared "unsustainable". The Audit Commission commented on the inadequate terms of the merger in 2009 for the financial health of the new NHS Trust but was not in a position to recommend future actions. The regulatory agencies had continued to focus a centrally implemented agenda on NHS Trust through inspections of services as well as financial audit.

The "solution" drawn up by the Trust Special Administrator shows that little has been learnt from the experience of merging NHS Trusts with deficits caused by PFI contracts. The merger of QEH with Lewisham Hospital is still in process but the deficit of the QEH will affect the new Trust. If the merged Trust becomes a Foundation Trust, the pressure to put financial risks before patient needs will become inevitable.

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Legislation

1990 Health and Community Care Act
1996 NHS (Residual Liabilities) Act
1997 National Health Services (Private Finance) Act
2003 Health and Social Care (Community Health and Standards) Act
2009 Health Act
2012 NHS and Social Care Act